Commonwealth of Massachusetts • Executive Office of Health and Human Services
600 Washington Street, Boston, MA 02111

Reset Form

Orthodontics Prior Authorization Form

For initial prior authorization, you must complete Parts I, II, and III. For each subsequent prior authorization, use a copy of the initially submitted form and complete Part IV.

Patient

Name: _____

Date of Birth: _____

Member Identification Number: _____

Orthodontist

Name: _____

Address: _____

_____

Telephone Number: _____

Provider Number: _____

Part I: Diagnosis Factors

Based on a preliminary evaluation, the factors checked below may have a significant bearing on the diagnosis or treatment:

- ☐ Pertinent medical history
- ☐ Oral hygiene/dental health
- ☐ Potential cooperation/motivation
- ☐ Dentofacial disfigurement, as perceived by patient and peers

Explain here: _____

_____

_____

_____

Part II: Description of Malocclusion

Brief description of malocclusion, including pertinent findings (for example, facial esthetics, classification, surgical treatment, and clefts):

_____

_____

_____

_____

_____

Part III: Treatment Objectives

Tentative treatment objectives, treatment plan, and mechanotherapy:

Part IV: Progress

Code	**Period**
D8670 (2)	From_____ (Month/Year) To_____ (Month/Year)
D8670 (3)	From_____ (Month/Year) To_____ (Month/Year)

Date treatment started: _____

Patient Cooperation: ☐ Yes ☐ No

Number appointments missed: _____

Include dated original and progress photographic prints.

Please submit the completed form, together with photographic prints, the PAR Index Recording Form, and the PA-1 form to the Orthodontic consultant, MassHealth, 600 Washington Street, Boston, MA 02111.

Date: _____ Signature: _____